STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The citations represent the findings of complaint investigation # 65351.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 180 residents. The sample included 3 residents. Based upon observation, record review and interviews the facility failed to revise the care plan for 2 (#1, #3) of the 3 sampled residents. Findings included:	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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- Review of resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 3/27/13 identified the resident was severely cognitively impaired, had signs and symptoms of delirium that included inattention, and disorganized thinking, displayed physical, verbal and behavioral symptoms directed toward others and other behavioral symptoms not directed toward others on daily basis, and rejected care on a daily basis. The MDS identified the resident required extensive staff assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene, did not walk in the room/corridor, and was totally dependent upon staff for locomotion on and off the unit. The MDS coded the resident was not steady, only able to stabilize with staff assistance when moved from seated to standing position, moving on and off the toilet, and surface to surface transfers. The MDS recorded the resident had an impairment in functional limitation in range of motion on one side of his/her lower extremity, was always incontinent of urine, and had not fallen since the prior assessment.

The resident's Behavioral Care Area Assessment (CAA) dated 1/16/13 documented the resident was disruptive to his/her environment when he/she yelled out, the resident was verbally and physically aggressive, resisted care, staff used a calm approach and 2 staff as needed, and the resident had medications to assist with his/her behaviors.

The resident's Fall CAA dated 1/16/13 included the resident was at risk for falls and had not fallen recently. The CAA included the resident utilized a stand up lift for transfers with assistance of 2 people, utilized a bed and chair alarm and fall

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mats on each side of his/her bed.

The resident's activities of daily living care plan reviewed/revised on 4/5/13 included the resident required staff assistance related to cognitive deficit, physical limitations, and impaired decision making. The care plan included staff explained procedures before starting and during the procedure. Staff followed the resident's consistent daily routine as closely as possible with assistance from a familiar staff as often as possible, if the resident resisted care, staff reproached the resident later or another staff approached the resident. On 4/5/13 the facility changed the resident's care plan from 2 person assistance with sit to stand lift to Hoyer lift at all times using a medium sling. On 5/15/13 the facility revised the resident's care plan to indicate staff utilized a small full sling when transferring the resident via the mechanical lift.

Review of the facility's 24 hour shift report (a communication tool for direct care staff) updated on 5/10/13 included staff transferred the resident via a full Hoyer lift using a full medium sized sling.

A physical therapy evaluation dated and signed by a physical therapist on 1/2/13 included staff transferred the resident via a stand up lift and needed physical therapy for transferring him/her using a Hoyer lift.

A physical therapy discharge summary dated 1/25/13 documented therapy staff trained nursing staff on how to perform safe and proper Hoyer lift transfers, staff demonstrated good understanding and to refer to the Teachable Moment notes.

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On 5/14/13 at 2:30 P.M. observation revealed the resident laid in a low bed with fall mats on both sides of the resident's bed. Further observation revealed a sling located on a mechanical lift in the resident's bathroom, and the tag on the sling indicated the size was small.

On 5/14/13 at approximately 2:35 P.M. direct care staff P stated staff had transferred the resident via a Hoyer lift the last couple of months or so, and the resident fell through the bottom of the sling a couple of weeks ago. Direct care staff P stated the facility communicated resident's care needs including the type and size of sling via the 24 hour report which staff carried in his/her pocket each day. Review of the 24 hour report at that time revealed staff transferred the resident via a Hoyer lift using a full body sized medium sling. Direct care staff P confirmed the size of the sling in the resident's room was small.

On 5/14/13 at approximately 2:40 P.M. licensed care staff H confirmed the size of the sling in the resident's room was a small and also confirmed the 24 hour report revealed staff transferred the resident using a size medium sling.

On 5/15/13 at approximately 10:00 A.M. direct care staff S and T transferred the resident using the mechanical lift and a small sized sling. The resident hit at staff and yelled during the transfer. Observation did not reveal any concerns with technique during the transfer.

On 5/15/13 at approximately 10:30 A.M. with administrative nursing staff F stated after the incident a licensed nurse assessed the resident and determined the resident needed a small

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sling. Administrative nursing staff F stated staff had transferred the resident with the small sling since the incident. Administrative nursing staff F confirmed the facility did not update the resident's care plan and/or 24 hour report to reflect the resident needed a small sling.

On 5/15/13 at approximately 12:30 P.M., administrative nursing staff D confirmed the resident's care plan did not reflect staff transferred the resident via a Hoyer lift using a medium sling until 4/5/13 (duration of 3 months).

The facility failed to revise the resident's care plan to reflect staff transferred the resident with a hoyer lift using a medium sling for a duration of 3 months and also failed to revise the resident's care plan until 5/15/13 after the size of the resident's sling changed.

- Review of resident #3's quarterly Minimum Data Set (MDS) 3.0 dated 2/12/13 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, required extensive staff assistance with bed mobility, and transfers, did not walk in the room/corridor, was totally dependent upon staff for locomotion on/off the unit, and required extensive staff assistance with dressing, toilet use, and personal hygiene. The MDS recorded the resident was not steady, only able to stabilize with staff assistance when moved from seated to standing position, moving on/off the toilet, and surface to surface transfers, and did not fall since the prior assessment.

The resident's Activities of Daily Living (ADLs) Care Area Assessment dated 11/26/12

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documented the resident required staff assistance with ADL's due to physical limitations and 2 staff transferred the resident via a sit to stand lift.

Review of the resident's care plan (on 5/14/13 at approximately 4:00 P.M.) dated 2/28/13 included 2 staff transferred the resident via a sit to stand lift.

Review of the resident's 24 hour shift report (a communication tool for direct care staff) updated 5/13/13 included staff transferred the resident via a Hoyer lift.

The 24 hour shift report and the resident's care plan failed to include what size sling the resident needed.

On 5/14/13 at approximately 3:45 P.M. the resident laid in bed and stated his/her left leg hurt. During interview with the resident at that time he/she stated staff transferred his/her via a mechanical lift.

On 5/14/13 at approximately 3:50 P.M. licensed nurse J stated the resident complained of leg pain the last couple of days or so, therefore staff transferred the resident via a mechanical lift versus the sit to stand lift.

On 5/14/13 at approximately 3:55 P.M. nursing administrative staff G confirmed the facility did not revise the resident's care plan regarding how staff transferred the resident via a hoyer lift versus the sit to stand lift.

The facility failed to revise the care plan

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F 280	Continued From page 6 concerning how staff transferred this dependent resident.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 180 residents. The facility identified 16 residents that utilized full body slings of which 3 were sampled. Based on observation, record review and interviews the facility failed to thoroughly assess the appropriateness of the type of sling prior to staff transferring a resident using a mechanical lift for 1 (#1) of 3 residents sampled for transfers. Findings included: - Review of resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 3/27/13 identified the resident was severely cognitively impaired, had signs and symptoms of delirium that included inattention, and disorganized thinking, displayed physical, verbal and behavioral symptoms directed toward others and other behavioral symptoms not directed toward others on daily basis, and rejected care on a daily basis. The MDS identified the resident required extensive staff assistance with bed mobility, transfers,	F 323		

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dressing, eating, toilet use, and personal hygiene, did not walk in the room/corridor, and was totally dependent upon staff for locomotion on and off the unit. The MDS coded the resident was not steady, only able to stabilize with staff assistance when moved from seated to standing position, moving on and off the toilet, and surface to surface transfers. The MDS recorded the resident had an impairment in functional limitation in range of motion on one side of his/her lower extremity, always incontinent of urine, and had not fallen since the prior assessment.

The resident's Behavioral Care Area Assessment (CAA) dated 1/16/13 documented the resident was disruptive to his/her environment when he/she yelled out, the resident was verbally and physically aggressive, resisted care, staff used a calm approach and 2 staff as needed, and the resident had medications to assist with his/her behaviors.

The resident's Fall CAA dated 1/16/13 included the resident was at risk for falls and had not fallen recently. The CAA included the resident utilized a stand up lift for transfers with assistance of 2 people, utilized a bed and chair alarm and fall mats on each side of his/her bed.

The resident's fall assessment dated 4/1/13 identified the resident scored 14 (moderate fall risk). The resident's fall assessment dated 4/18/13 identified the resident scored 16 (high risk for falls).

The resident's activities of daily living care plan reviewed/revised on 4/5/13 included the resident required staff assistance related to cognitive

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deficit, physical limitations, and impaired decision making. The care plan included staff explained procedures before starting and during the procedure. Staff followed the resident's consistent daily routine as closely as possible with assistance from a familiar staff as often as possible, if the resident resisted care, staff reproached the resident later or another staff approached the resident. On 4/5/13 the facility changed the resident's care plan from 2 person assistance with sit to stand lift to Hoyer lift at all times using a medium sling. On 5/15/13 the facility revised the resident's care plan to indicate staff utilized a small full sling when transferring the resident via the mechanical lift.

The resident's care plan reviewed/revised on 4/5/13 included the resident's behavior was problematic, the resident had ineffective coping mechanism, agitation related to his/her psychiatric illness, cognitive impairment, physical aggression, grabbing or hitting, and hollering out. The care plan included interventions regarding resident to resident agitation. The resident's care plan included the resident was at risk for injury related to falls characterized by a history of falls, cognitive impairment, use of psychotropics or other medications, poor safety judgement, reduced vision, and pain. The care plan included staff placed mats on the floor on both sides of the resident's bed, the facility provided consistent caregivers as possible, and the resident was easily over stimulated and became irritable and/or agitated.

Review of the facility's 24 hour shift report (a communication tool for direct care staff) updated on 5/10/13 included staff transferred the resident

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via a full Hoyer lift using a full medium sized sling.

A physical therapy evaluation dated and signed by a physical therapist on 1/2/13 included staff transferred the resident via a stand up lift and needed physical therapy for transferring him/her using a Hoyer lift.

A physical therapy discharge summary dated 1/25/13 documented therapy staff trained nursing staff on how to perform safe and proper Hoyer lift transfers. Staff demonstrated good understanding and to refer to the Teachable Moment note.

A Teachable Moment dated and signed by a certified physical therapist assistant on 1/17/13 included all staff felt comfortable with the Hoyer lift and correct sling placement. Review of the teachable moment revealed 4 staff (3 day shift staff and 1 evening shift staff) signed the attendance log.

A nurse's note dated 9/6/12 and timed 1:44 P.M. included the resident was agitated and combative to staff at 12:30 P.M.

A nurse's note dated 10/7/12 and timed 9:48 P.M. documented the resident had episodes of yelling out, and when staff helped the resident he/she would hit staff.

A nurse's note dated 12/8/12 and timed 10:11 A.M. included when staff went in to get the resident up and dressed for the day, the resident hit and scratched the staff.

A nurse's note dated 3/25/12 and timed 7:51 P.M.

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included 2 staff transferred the resident with a mechanical lift, the resident yelled out while in the bed, and the resident scratched, pinched and hit staff during cares.

A nurse's note dated 4/18/13 and timed 11:24 A.M. included the resident laid on the floor in the shower room with his/her pants down. The note documented the resident hit his/her head on the bathroom floor and had a small laceration on the back of his/her head. The note included staff reported the resident swung at the nurse aide student, and the resident fell through the bottom of the lift sling. The note included the facility notified the resident's physician and obtained an order to send the resident to a local emergency room (ER).

A nurse's note dated 4/18/13 and timed 1:03 P.M. documented ER staff reported the contusion to the resident's head was superficial, ER staff cleansed the area and applied Neosporin (an antibiotic ointment).

On 5/14/13 at 2:30 P.M. observation revealed the resident laid in a low bed with fall mats on both sides of the resident's bed. Further observation revealed a sling located on a mechanical lift in the resident's bathroom, and the tag on the sling indicated the size was small.

On 5/13/13 at approximately 8:30 A.M. observation revealed a small sized sling on the resident's bed.

On 5/14/13 at approximately 2:35 P.M. direct care staff P stated staff transferred the resident via a Hoyer lift the last couple of months or so, and the

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resident fell through the bottom of the sling a couple of weeks ago. Direct care staff P stated the facility communicated resident's care needs including the type and size of sling via the 24 hour report which staff carried in his/her pocket each day. Review of the 24 hour report at that time revealed staff transferred the resident via a Hoyer lift using a full body medium sized sling. Direct care staff P confirmed the size of the sling in the resident's room was small.

On 5/14/13 at approximately 2:40 P.M. licensed care staff H confirmed the size of the sling in the resident's room was a small and also confirmed the 24 hour report revealed staff transferred the resident using a medium sized sling.

On 5/14/13 at approximately 2:50 P.M. direct care staff Q stated on the date of the incident he/she was one of the individuals who transferred the resident when the resident fell through the bottom of the sling. Direct care staff Q stated the resident used a medium sized toileting sling which had an opening around the seat, no back support on the sling, and the resident fell through the opening. Direct care staff Q stated the sling allowed staff to easily maneuver the resident's clothing during care because the resident was combative during care. Direct care staff Q, stated on the date of the incident, he/she and a nurse aide student showered the resident, he/she had raised the lift to dry the resident's buttock, the resident started hitting at the student and the resident fell through the bottom of the sling. Direct care staff Q stated he/she did not receive training regarding the Hoyer lift for this resident prior to the incident. Direct care staff Q confirmed the size of the sling in the resident's room as a

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size small. Direct care staff Q stated if a resident utilized a full body sling the sling remained in the resident's room unless sent to laundry. Direct care staff Q stated if the sling needed laundering, then staff retrieved a sling from central supply. Direct care staff Q stated he/she used the 24 hour report or the resident's care plan to determine the size of the sling the resident utilized.

On 5/14/13 at approximately 3:00 P.M. administrative nursing staff F stated after the incident regarding the resident falling through the sling, he/she assessed all residents who utilized slings to ensure staff used the appropriate sling and size. Administrative nursing staff F stated the resident used a medium size hygiene sling prior to the incident, the hygiene sling did not have a back and the resident fell though the opening. Administrative nursing staff F stated after the incident, staff was instructed to use a full medium size body sling. Administrative nursing staff F stated the color of the tag on the sling indicated the size of the sling and the size was based upon the resident's weight. Observation revealed there was no information on the sling or in the vicinity of the sling that allowed one to correlate the color of the tag to the size of the sling. Administrative nursing staff F confirmed there was no color coded information on the tag or the lift. Administrative nursing staff F confirmed the sling in the resident's room was a small. Administrative nursing staff F stated prior to the incident, the facility did not have a formal system to assess the appropriate sling for each resident.

On 5/15/13 at approximately 9:45 A.M. direct care

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staff R stated the sling the resident utilized prior to the incident was a sling designed for toileting. Direct care staff R stated if the resident's hands did not remain on the outside of the sling, the resident could fall through the opening of the sling.

On 5/15/13 at approximately 10:00 A.M. direct care staff S and T transferred the resident using the mechanical lift and a small sized sling. The resident hit at staff and yelled during the transfer. Observation did not reveal any concerns with technique during the transfer. Direct care staff S confirmed he/she did not receive training regarding the Hoyer lift for this resident prior to the incident.

On 5/15/13 at approximately 10:30 A.M. with administrative nursing staff F stated after the incident a licensed nurse assessed the resident and determined the resident needed a small sling. Administrative nursing staff F stated staff transferred the resident with the small sling since the incident. Administrative nursing staff F confirmed the facility did not update the resident's care plan and/or 24 hour report to reflect the resident needed a small sling. Administrative nursing staff identified the resident wore a Hygiene Sling model 40 type of sling prior to the incident. Administrative nursing staff F stated the sling was a safety hazard and demonstrated why he/she felt the sling was unsafe for the resident. Observation revealed there was no front or back support. Nursing administrative staff F stated he/she had ordered the sling with a support vest that would prevent a resident from following through the opening on the sling. Administrative nursing staff F stated he/she placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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laminated color coded cards on the Hoyer lifts yesterday evening after 3:00 P.M. Administrative nursing staff F stated staff placed the size of the slings on the 24 hour report on 4/19/13.

On 5/15/13, at approximately 12:30 P.M., administrative nursing staff D stated therapy assessed residents prior to staff transferring residents with a mechanical lift to determine which lift was appropriate. Administrative nursing staff D stated the therapist assessment should include assessing for the appropriate sling. Administrative nursing staff D stated if staff did not think the sling therapy had in place was appropriate, the licensed nurse could assess the appropriateness of a sling. Administrative nursing staff D confirmed the resident fell through the opening of the sling. Administrative nursing staff D confirmed the 24 hour report was a communication tool staff used when providing care for residents.

On 5/15/13 at approximately 1:00 P.M. contracted therapy staff Z stated he/she provided education to the staff regarding safe transfers for the resident when the resident went from a sit to stand lift to a full mechanical lift. Contracted therapy staff Z stated during the time he/she provided education to the staff the resident utilized a full body sling.

According to the product information the Liko Hygiene Sling was recommended especially for: lifting in connection with hygiene/visits to the toilet, residents with good muscle tone and a need for a sling that was easy to apply and remove. The Hygiene Sling was available in four different models. Model 40 was the simplest

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F 323	Continued From page 15 design fitting residents with good muscle tone, good stability and the resident's arms were positioned on the outside of the sling. The facility's mechanical lift policy and procedure approved 1/2007 included residents who were unable to bear his/her own weight staff would transfer using a mechanical device, staff followed the procedure for Using Mechanical Lifts found on pages 244-248 of Pocket Guide to Basic Skills and Procedures, 6 th Edition, and the manufacturer's directions were in the reference book at the nursing desk. The facility to access the appropriateness of the sling for this severely cognitively resident with a history of physical behaviors during care.	F 323		